PRINTED: 03/22/2013 FORM APPROVED OMB NO. 0938-0391

			(X3) DATE SURVEY COMPLETED				
		185229	B. WING				C / 18/2012
	OVIDER OR SUPPLIER	CENTER	•	300	ET ADDRESS, CITY, STATE, ZIP CODE WESTWOOD ST. ASGOW, KY 42141	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 000	#19447) was conduct 12/18/12. KY #19443 deficiencies cited. Im Substandard Quality 12/17/12 and determid 42 CFR 483.13 Resideractices, F 223 and severity of a "J". On 11/22/12, betwee Certified Nursing Ass CNA #1 cross Reside chest and push him/r door; the door slamm sustained a bruise to CNA #1 was witnessed the resident's drawer clothing in the residengive you something to witnessed to be upsered to be	al extended survey (KY ted on 12/13/12 through was substantiated with mediate Jeopardy and of Care was identified on ined to exist on 11/22/12 at dent Behavior and Facility F226, at a scope and n 12:00 Noon and 1:00 PM, istant (CNA) #2 witnessed ent #1's arms across his/her ier in the wheelchair into the	F	000	DEFICIENCY)		
ADODATORY	Care was determined	and Substandard Quality of I to exist on 11/22/12			TITI F		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 03/22/2013 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NI IMPED:		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		185229	B. WING _			C 12/18/2012	2
	ROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 300 WESTWOOD ST. GLASGOW, KY 42141	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIA		ETION
F 000	through 12/03/12. The corrective action prior Agency's investigation determined Past Jeop	e facility implemented to the State Survey n on 12/13/12, thus it was	FC	000			
F 223	ABUSE/INVOLUNTA The resident has the sexual, physical, and punishment, and invo The facility must not uor physical abuse, co involuntary seclusion.	RY SECLUSION right to be free from verbal, mental abuse, corporal fluntary seclusion. use verbal, mental, sexual, rporal punishment, or	F2	223			
	personnel time record policy and procedure determined the facility system to ensure each verbal and physical at the selected sample of 11/22/12, between 12 Certified Nursing Ass CNA #1 cross Reside chest and push him/h door; the door slamm sustained a bruise to CNA #1 was witnesse the resident's drawer	record review, review of ds and review of the facility's and investigation it was y failed to have an effective th resident was free from buse for one resident (#1) in of three residents. On 2:00 Noon and 1:00 PM, istant (CNA) #2 witnessed ent #1's arms across his/her ter in the wheelchair into the ed; and the resident the forearm. Additionally, ed to remove clothing from and throw some of the nt's face, stating "this will		Past noncompliance: no pl correction required.	an of		

Facility ID: 100509

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		INSTRUCTION	(X3) DATE SURVEY COMPLETED		
		185229	B. WING				C / 18/2012	
	COUNTY HEALTH CARE	E CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 300 WESTWOOD ST. GLASGOW, KY 42141		·		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 223	witnessed to be upser Resident #1's room a witnessed to License However, LPN #1 did direct resident care. work, providing care end of her shift at 3:0 #2 reported what she Registered Nurse (RI the Administrator and the allegation. The corevealed there was p abuse by CNA #1 tov #1 was terminated. The failure to ensure verbal and physical at to cause, serious injudeath to Resident #1 facility. Immediate Jo Quality of Care was of 11/22/12 through 12/ implemented correcti Survey Agency's inverse was determined Past Jeopardy was determ 12/04/12. The findings include: Review of the "Resid Exploitation" policy/p any incident of abuse be reported immedia staff person (usually responsible for the re-	o do". Resident #1 was at and crying. CNA #2 left and reported what she ad Practical Nurse (LPN) #1. If not remove CNA #1 from CNA #1 was allowed to to other residents, until the 20 PM. On 11/23/12, CNA at witnessed the day before to N) #1, and RN #1 contacted do initiated an investigation of completed investigation of completed investigation of sossible mental and physical wards Resident #1 and CNA residents were free from abuse has caused, or is likely ary, harm, impairment, or and other residents in the ecopardy and Substandard determined to exist on 03/12. The facility are action prior to the State destigation on 12/13/12, thus it it Jeopardy. The Immediate mined to be removed on ent Abuse, Neglect, and rocedure, undated, revealed a or suspected abuse must tely to the available charge	F	223				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185229	B. WING			C 12/18/2012	
	COUNTY HEALTH CARE	L		STI	REET ADDRESS, CITY, STATE, ZIP CODE 300 WESTWOOD ST. GLASGOW, KY 42141	<u> 12/</u>	16/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B' CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 223	written grievances bu complaint. The individe abuse was to be remove the put on administration was consummed administrator. The D and Administrator we by the charge person report. A review of the facility 11/29/12, revealed arreported on 11/22/12 approximately 1:00 P between CNA #1 and scratched CNA #2 whis/her room. CNA # hands, crossed them pushed his/her wheel causing the door to si sustained a bruise to determined there was	t may include a verbalized dual suspected of causing oved from the the facility and ive leave until the inpleted and an on was made by the irector of Nursing (DON) are to be notified immediately who initially received the vis investigation, dated in allegation of abuse was . On 11/22/12 at M, an incident occurred I Resident #1. Resident #1 inite assisting the resident in 1 grabbed Resident #1's across his/her chest and chair against the door, am shut and the resident the forearm. The facility	F	223			
	revealed she witness #1 and Resident #1 on Noon and 1:00 PM. S "shock" because she #1 act that way before was trying to go down intercepted the reside back to his/her room was working on the high get the resident back.	2, on 12/13/12 at 2:36 PM, ed an incident between CNA on 11/22/12 between 12:00 She revealed she was in had never observed CNA e. She reported Resident #1 on the brown hall when she ent and escorted him/her on the white hall. CNA #1 all and she assisted her to to his/her room. Resident me and the resident dug					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	FIPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED	
		185229	B. WING _			C 2/18/2012	
	ROVIDER OR SUPPLIER	E CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 300 WESTWOOD ST. GLASGOW, KY 42141			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 223	in the room, CNA #1 across his/her chest was in his/her wheel slammed; and, the re the forearm. Reside and had a scared loograbbed clothes from tossed them on the band threw them at R will give you someth she stood there and CNAs left the room anursing desk. CNAs LPN #1. The nurse write the situation up wait until the next da Registered Nurse (R did not look into the standard to slam on clothes in Resident #1 she denied shoving causing it to slam on clothes in Resident #7 room with CNA #2. adjoining bathroom anot see anything but to ask about the nois Resident #1 had rolle because he/she was #1's room because seresident down and we stated there was a nouldn't recall who a anything to the nurse report anything to the	A #2's arm. Once they were crossed Resident #1's arms and pushed the resident who chair into the door; the door esident sustained a bruise to ent #1 was upset and crying ok on his/her face. CNA #1 in the resident's drawer, bed and then picked them up esident #1's face stating "this ing to do". CNA #2 revealed did not do anything. The and walked up the hall to the #2 reported the incident to verbalized she would have to and she voiced she would y to report the situation to N) #1. She stated LPN #1	F2	223			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185229	B. WING			1	C 18/2012
	ROVIDER OR SUPPLIER	CENTER		300	ET ADDRESS, CITY, STATE, ZIP CODE WESTWOOD ST. ASGOW, KY 42141		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 223	staff came to her and to an allegation of about an allegation of about A review of a time rep 11/22/12, revealed Cluntil 3:00 PM. She has from 10:30 AM until 11:15 PM. An interview with LPN AM, revealed she was facility on 11/22/12. A approached her and rowas informed that CN resident in his/her who threw clothes in his/her who threw clothes in his/her cNA #2 they should rowas anything to the of allowed to work until the PM. She revealed she was anything to the of allowed to work until the PM. She revealed she was anything to the of allowed to work until the PM. She revealed she was anything to the of allowed to work until the PM. She revealed she was abuse previously and facility's abuse policy "alleged perpetrator" even though she had procedure upon hire and the PM, revealed she was allowed to was a facility and procedure upon hire and the PM, revealed she was allowed to was a facility and procedure upon hire and the PM, revealed she was allowed to was a facility and procedure upon hire and the procedure upon hire and the pM, revealed she was anything the procedure upon hire and the pM, revealed she was anything the procedure upon hire and the pM.	of her shift at 3:00 PM. No asked her to leave related use. Fort for CNA #1, for NA #1 worked from 6:00 AM and a break at 9:15, lunch 1:00 AM and a break at If #1, on 12/14/12 at 9:25 is the nurse working in the After lunch, CNA #2 reported an allegation. She lad #1 had pushed the eelchair into the door and er face. She explained to report the incident to the lite hall and CNA #2 asked reg to that nurse because se were friends. She did not ther nurse and CNA #1 was the end of her shift at 3:00 red did not check on Resident th CNA #1 and remove her ted CNA #2 was left with the lowith the allegation. She returned to her assigned if she had never dealt with was not aware of the requiring the removal of an from resident care areas received the policy and and signed it.	F	223			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185229	B. WING				C 18/2012
	OVIDER OR SUPPLIER	CENTER	•	30	EET ADDRESS, CITY, STATE, ZIP CODE 00 WESTWOOD ST. 6LASGOW, KY 42141	,	10,10
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 223	the day before. CNA the resident's arms are and pushed him/her in picked up some cloth his/her face. She que was in the building ar was not on duty. RN Administrator and Ass (ADON); take statemed an assessment on Referesident's physician at An interview with the at 1:18 PM, revealed 11/22/12. He received RN #1 who stated she allegation that occurre inquired about the "all informed she was not RN #1 to notify CNA administrative leave prince incident immediately the nurse and the nur the perpetrator and constated they had a faill the complaint to follow place. The completed there was possible m towards Resident #1. because it was one stout determined they stout the stout of the stout determined they stout determined they stout the stout of the stout determined they stout the stout of the stout determined they stout on the stout of the stout	2) related to CNA #2 n of abuse that took place #2 alleged CNA #1 crossed cross the resident's chest nto the door. She then ing and threw them in estioned RN #1, if CNA #1 nd she was informed she #1 was advised to notify the esistant Director of Nursing ents from the staff; complete esident #1; and, the nd family about the incident. Administrator, on 12/13/12 he was not in the facility on ed a telephone call from had received an abuse ed the day before. He leged perpetrator" and was in the building. He advised #1 she was on bending the results of the ected the staff to report the (as soon as it happened) to se was expected to remove all the DON and him. He cure of the nurse receiving with the policy/procedure in d investigation revealed ental and physical abuse He revealed it was unclear taff's word against the other should separate CNA #1 11/29/12, CNA #1 was minated.	F	223			

AND DLAN OF CORRECTION IDENTIFICATION NUMBER		l ` ′	2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		185229	B. WING			l	C 18/2012
	COUNTY HEALTH CARE	L		3	REET ADDRESS, CITY, STATE, ZIP CODE 100 WESTWOOD ST. GLASGOW, KY 42141	<u> 121</u>	10/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 223	admitted to the facility to include Depressive Abdominal Aortic And Bone. A review of the Set (MDS) Assessment the facility assessed the facility assessed the facility impaired. **The facility implement correct the deficiency *On 11/23/12, Register an investigation of the of Resident #1. She is Administrator of the anotification, the Adminant coordinated the inwere conducted and being off on administration. *The family was notified by RN #1 on 11/23/12 *The MD of the affect the allegation by RN is the Administrator of the affect the allegation by RN is the Administrator of the affect the allegation by RN is the Administrator of the Administrator of the affect the allegation by RN is the Administrator of the Ad	on 12/24/07 with diagnoses bisorder, Insomnia, surysm, and Neoplasm of equarterly Minimum Data ant, dated 11/05/12, revealed the resident as severely sented the following actions to a callegation of mistreatment notified the DON and allegation. Following nistrator arrived to the facility investigation. Interviews CNA #1 was informed of a rative leave pending an an ed of the allegation of abuse 2. Seed resident was notified of #1 on 11/23/12. COIG/DCBS was completed on 11/23/12. Sekin assessment of Resident pricing noted to the signed licensed staff assents of all residents and not identify any	F	223			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185229	B. WING				C 18/2012
	COUNTY HEALTH CARE	CENTER		30	EET ADDRESS, CITY, STATE, ZIP CODE 0 WESTWOOD ST. LASGOW, KY 42141	1 121	10/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 223	policy/procedure prior scheduled shift by RN Development Coordin started on 11/23/12 a One LPN was on medithe education prior to *The Abuse Coordinaresidents living on the they had received from residents were asked ever mistreated them the facility had mistre *The Administrator in Improvement on "Abuse Reporting" on 12/12/12 the staff on each shift policy and what they saff on each shift policy and what they are sidents had their sk from 11/22/12 through did not identify any in Observation, on 12/13 of the resident's interaresident appeared afresident appeared afresident provided. with interviewable residents.	ication on the abuse/neglect to starting their next I #1 and the Staff nator (SDC). Training was not completed on 12/03/12. Idical leave and will receive returning to work. It on 11/27/12 interviewed white hall about the care mestaff. The interviewable specifically if CNA #1 had and all reported "no one in ated them". It itated Continuous Quality use Investigation and I2 and they would be asking to verbalize the abuse are expected to do. It did the corrective action is follows: In pled residents and the in assessments completed in 11/29/12. The facility staff in it is follown origin. In a staff, revealed no aid of the staff while care interviews, on 12/13/12, idents, revealed the staff ite residents denied being lity staff.	F	223			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		185229	B. WING				С
		105229	B. WING	I		12/	18/2012
	OVIDER OR SUPPLIER COUNTY HEALTH CARE	CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 300 WESTWOOD ST. GLASGOW, KY 42141			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 223	Continued From page	9	F	223			
		ated to the abuse/neglect 11/23/12 and completed on					
	CNA #3, on 12/14/12 12/14/12 at 2:40 PM, AM, LPN #2, on 12/14/12 at 2:5 knowledgeable and a understanding of the staff person was able responsibilities were heard something that Interview with CNA # revealed they were to charge nurse as soon nurse did not responding the facility. I #2, and RN #2 reveal of abuse, they were to abusing the resident at the staff person of the staff person was able to the staff person was a	abuse/neglect policy. Each to verbalize what their if they observed or over was abusive or neglectful. 2, CNA #3, and CMA #1 oreport abuse/neglect to the as it was witnessed. If the d, they are to tell another interview with LPN #1, LPN ed upon receiving a report oremove the person and protect the resident, N and Administrator of the					
	12/14/12 at 3:16 PM, staff about abuse in converted with the Adminvestigation of abuse they were to report at to the nurse. The nur	inistrator and DON during an e. She informed the staff buse as soon as it happens rese was expected to remove acility, ensure the resident the allegation to the					
		DON, on 12/17/12 at 9:00 as educated on 11/23/12					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	IPLE CONSTRUCTION IG	(X3) DATE SUR COMPLETE	
		185229	B. WING _		C 12/18/2	2012
	OVIDER OR SUPPLIER	CENTER	'	STREET ADDRESS, CITY, STATE, ZIP CODE 300 WESTWOOD ST. GLASGOW, KY 42141	1 12/10/2	.012
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE CC	(X5) DMPLETION DATE
F 223	what each level of stare-training was very that interviewed staff what to do if a patient they had not identified have responded appropriately applied to the staff randomly applicy. The ADON ar Coordinator complete staff. We did not idenable to recite what to interview, the Medica the incident when the 483.13(c) DEVELOP/ABUSE/NEGLECT, E	and asked them to explain was abused. Per interview, dany problems and the staff opriately. Administrator, on 12/17/12 after the incident, the staff serviced on our abuse policy. Started related to talking to out what the current abuse of Staff Development define and staff who were not do in case of abuse. Per I Director was informed of facility became aware. IMPLMENT TO COLICIES Belop and implement written es that prohibit and abuse of residents	F 2			
	by: Based on interview, the facility's policy an investigation it was do to have an effective s	etermined the facility failed		Past noncompliance: no plan of correction required.		

02.1.2.1	C . C. t EDIO/ II LE C	T OLIVIOLO					2. 0000 000 1
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
						(С
		185229	B. WING			1	18/2012
NAME OF PF	ROVIDER OR SUPPLIER	1		STRI	EET ADDRESS, CITY, STATE, ZIP CODE		
					00 WESTWOOD ST.		
BARREN	COUNTY HEALTH CAR	E CENTER			LASGOW, KY 42141		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	<u> </u>	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREF	IX	(EACH CORRECTIVE ACTION SHOULD E	Æ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	i	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE
			_		BEI IOIENOT)		
E 000	0 11 15	44	_				
F 226	Continued From pag		F	226			
	· •	ent (#1), in the selected					
	1	dents, from abuse. The					
		re protection of residents					
	_	abuse, by allowing the					
		to continue to provide direct					
		On 11/22/12, between 12:00					
	I .	Certified Nursing Assistant					
	, ,	CNA #1 cross Resident #1's					
		chest and push him/her in					
		he door; the door slammed;					
		tained a bruise to the y, CNA #1 was witnessed to					
		n the resident's drawer and					
	_	othing in the resident's face,					
		you something to do".					
	_	nessed to be upset and					
		Resident #1's room and					
	reported what she w						
	1 -	I) #1. However, LPN #1 did					
	,	from direct resident care.					
		I to work, providing care to					
	other residents, until	the end of her shift at 3:00					
	PM. On 11/23/12, C	NA #2 reported what she					
	witnessed the day be	efore to Registered Nurse					
	(RN) #1, and RN #1	contacted the Administrator					
	and initiated an inves	stigation of the allegation.					
		stigation revealed there was					
	1 -	physical abuse by CNA #1					
	towards Resident #1						
	terminated. (Refer to	F223)					
	The failure to encure	the protection of residents					
	I .	the protection of residents					
	_	abuse has caused, or is					
	1	us injury, harm, impairment, #1 and other residents in the					
	1	eopardy and Substandard					
		determined to exist on					
	11/22/12 through 12/						
	,, <i>,</i> , _ u ii ouqii 1 <i>_</i> /		1	- 1			1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG	COMPLE	(X3) DATE SURVEY COMPLETED		
		185229	B. WING _		C 12/18	8/2012		
NAME OF PROVIDER OR SUPPLIER BARREN COUNTY HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 300 WESTWOOD ST. GLASGOW, KY 42141	,			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDEPICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 226	Survey Agency's inv was determined Pas Jeopardy was deter 12/04/12. The findings include Review of the "Resi Exploitation" policy/any incident of abus be reported immedia staff person (usually responsible for the r duty). The report wwitten grievances be complaint. The indiabuse was to be rer be put on administration vas conditional administrative decis administrative decis administrator. The land Administrator who the charge person report. A review of the facilial 11/29/12, revealed a reported on 11/22/1 approximately 1:00 between CNA #1 ar scratched CNA #2 whis/her room. CNA hands, crossed ther	tive action prior to the State vestigation on 12/13/12, thus it at Jeopardy. The Immediate mined to be removed on dent Abuse, Neglect, and procedure, undated, revealed se or suspected abuse must ately to the available charge of the charge nurse resident's care on their tour of as not limited to formal or but may include a verbalized widual suspected of causing moved from the the facility and ative leave until the completed and an ion was made by the Director of Nursing (DON) here to be notified immediately in who initially received the sty's investigation, dated an allegation of abuse was 2. On 11/22/12 at PM, an incident occurred and Resident #1. Resident #1 while assisting the resident in #1 grabbed Resident #1's in across his/her chest and	F 2					
	approximately 1:00 between CNA #1 ar scratched CNA #2 whis/her room. CNA hands, crossed ther pushed his/her where causing the door to sustained a bruise to	PM, an incident occurred and Resident #1. Resident #1 while assisting the resident in #1 grabbed Resident #1's						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		185229	B. WING				C 12/18/2012	
NAME OF PROVIDER OR SUPPLIER BARREN COUNTY HEALTH CARE CENTER			•	;	REET ADDRESS, CITY, STATE, ZIP CODE 300 WESTWOOD ST. GLASGOW, KY 42141			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE		
F 226	Interview with LPN #1 and 12/17/12 at 3:24 charge of the brown, facility on 11/22/12. Callegation of abuse af LPN #1, on 12/14/12 was the nurse workin After lunch, CNA #2 an allegation that CN resident in his/her whithrew clothes in his/her whithrew clothes in his/her cNA #2 about reportinurse in charge of the lived, but she did not she left the decision udo then she returned reported she did not lidid she check Reside not been injured. CN direct care until the else about the incider and verbalized she "histreated". She had abuse/neglect in the pmessage to the DON informed the DON of being said. The DON what to do if another reviewed the policy of and took a test over it acknowledge if she kill	NA #1 was terminated I, on 12/14/12 at 9:25 AM PM, revealed she was in gold and orange hall of the NA #2 reported to her an iter lunch. An interview with at 9:25 AM, revealed she g in the facility on 11/22/12. Approached her and reported A #1 had pushed the eelchair into the door and er face. She talked with ang the incident to the other hall where Resident #1 want to. LPN #1 reported up to CNA #2 about what to to work on her halls. She et the other nurse know nor not #1 to ensure he/she had A #1 continued to provide and of her shift at 3:00 PM. For CNA #2 saying anything ant; however, she was upset wated to see residents and she sent a text. LPN #1 reported she the incident and what was a informed her specifically incident happened. She in abuse/neglect when hired incident but verbalized she	F	226				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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NAME OF PR	NAME OF PROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE	12/	18/2012		
BARREN COUNTY HEALTH CARE CENTER					WESTWOOD ST. ASGOW, KY 42141				
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F 226	Interview with Registed 12/13/12 at 3:01 PM, aware of the abuse at CNA #2 and she notified Administrator of the adquestioned if CNA #1 informed she was not to call CNA #1 and in administrative leave purchased to call CNA #1 and in administrative leave purchased to call CNA #1 and in administrative leave purchased to call CNA #1 and in administrative leave purchased to call CNA #1 and in administrative leave purchased to call CNA #1 and in administrative leave purchased investigation. An interview with the PM, revealed she was 11/22/12; however, succeed to Saturday. She informed specifically policy/procedure was accused (CNA #1) not direct care as this allestated LPN #1 did not she was made aware inform her charge nuthe issue with the "all sending her home and per the policy. An interview with the "1:00 PM, revealed her 1:00 PM, revealed her 1:0	ered Nurse (RN) #1, on revealed she was made llegation on 11/23/12, by fied the DON and illegation. The Administrator was on duty and he was to the then gave instructions form her she was on pending an investigation. The interest of the months of the mon	F	226					

PRINTED: 03/22/2013 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PF	ROVIDER OR SUPPLIER	185229	B. WING		EET ADDRESS, CITY, STATE, ZIP CODE	12/	18/2012
BARREN COUNTY HEALTH CARE CENTER		CENTER		3	00 WESTWOOD ST. BLASGOW, KY 42141		
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F 226	made aware CNA #2 abuse, but she did not the protection of resic completed investigati possible mental and p was terminated 11/25 **The facility impleme correct the deficiency *On 11/23/12, Regist an investigation of the of Resident #1. She Administrator of the a notification, the Admi and coordinated the i were conducted and being off on administr investigation. *The family was notifi by RN #1 on 11/23/12 *The MD of the affect the allegation by RN is *Self report incident to by the Administrator of *RN #1 completed a s #1 on 11/23/12 with b resident's left arm. A conducted skin assess	is investigation, he was informed LPN #1 of the of follow the policy related to dents. The facility's on revealed there was obysical abuse and CNA #1 0/12. Intended the following actions to read Nurse (RN) #1 initiated a allegation of mistreatment notified the DON and allegation. Following mistrator arrived to the facility investigation. Interviews CNA #1 was informed of rative leave pending an and allegation of abuse 2. Intended of the allegation of abuse 3. Intended of the all	F	226			

The state of the s		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER BARREN COUNTY HEALTH CARE CENTER				STR 3	REET ADDRESS, CITY, STATE, ZIP CODE 00 WESTWOOD ST. GLASGOW, KY 42141	<u> 12/</u>	18/2012
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F 226	*All staff received edupolicy/procedure prior scheduled shift by RN Development Coordin started on 11/23/12 a One LPN was on med the education prior to *The Abuse Coordinaresidents living on the they had received from residents were asked ever mistreated them the facility had mistre *The Administrator in Improvement on "Abu Reporting" on 12/12/12 the staff on each shift policy and what they at the staff on each shift policy and what they at the staff on the residents residents residents had their sk from 11/22/12 through did not identify any in Observation, on 12/13 of the resident's interaresident appeared afresident appeared afresident was being provided. with interviewable residents.	acation on the abuse/neglect to starting their next at #1 and the Staff actor (SDC). Training was and completed on 12/03/12. Addical leave and will receive returning to work. Attor on 11/27/12 interviewed white hall about the care mostaff. The interviewable specifically if CNA #1 had and all reported "no one in acted them". Attack Continuous Quality are Investigation and all and they would be asking to verbalize the abuse are expected to do. Attack the corrective action are follows: An and all reported "no one in acted them". Attack Continuous Quality are Investigation and all and they would be asking to verbalize the abuse are expected to do. Attack the corrective action are in assessments completed in 11/29/12. The facility staff furies of unknown origin. Barray 12/14/12, and 12/17/12 action with staff, revealed no acid of the staff while care Interviews, on 12/13/12, aidents, revealed the staff are residents denied being	F	226			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER BARREN COUNTY HEALTH CARE CENTER				300	ET ADDRESS, CITY, STATE, ZIP CODE D WESTWOOD ST. ASGOW, KY 42141	127	10/2012	
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F 226	policy/procedure, on 12/03/12. Interview with CNA # CNA #3, on 12/14/12 12/14/12 at 2:40 PM, AM, LPN #2, on 12/14/12 at 2:5 knowledgeable and a understanding of the staff person was able responsibilities were in heard something that Interview with CNA # revealed they were to charge nurse as soon nurse did not respondingse in the facility. I #2, and RN #2 reveal of abuse, they were to abusing the resident anotify the DON/ADON allegation, and start at An interview with Soot 12/14/12 at 3:16 PM, staff about abuse in convexed with the Adminivestigation of abuse they were to report at to the nurse. The nur	ted the completion of ated to the abuse/neglect 11/23/12 and completed on 2, on 12/13/12 at 2:36 PM, at 2:15 PM, CMA #1, on LPN #1, on 12/14/12 at 9:25 4/12 at 10:05 AM and RN 50 PM revealed they were ble to verbalize abuse/neglect policy. Each to verbalize what their if they observed or over was abusive or neglectful. 2, CNA #3, and CMA #1 or report abuse/neglect to the as it was witnessed. If the d, they are to tell another interview with LPN #1, LPN ed upon receiving a report or remove the person and protect the resident, N and Administrator of the in investigation. Dial Services Director, on revealed she instructed the orientation. She often inistrator and DON during an each of the staff ouse as soon as it happens are was expected to remove accility, ensure the resident the allegation to the	F	226				
	An interview with the	DON, on 12/17/12 at 9:00						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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		185229	B. WING			12/	18/2012		
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F 226	AM, revealed staff ware regarding the abuse what each level of stare-training was very thad interviewed staff what to do if a patienthey had not identifie have responded appropriately. An interview with the at 3:05 PM, revealed were immediately insome the staff randomly abpolicy. The ADON at Coordinator complete staff. We did not idea able to recite what to interview, the Medica	as educated on 11/23/12 policy, going over specifically aff was expected to do. The horough. She stated they and asked them to explain t was abused. Per interview, d any problems and the staff	F	226					